

WELCOME TO OUR OFFICE

PATIENT'S NAME _____ SEX: M ___ F ___

HOME ADDRESS _____ CITY _____ ZIP CODE _____

AGE _____ BIRTHDATE _____ HOME PHONE _____

OCCUPATION _____

Employer _____ Business Phone _____

PERSON RESPONSIBLE FOR ACCOUNT _____

Status: Single _____, Married _____, Separated _____, Divorced _____, Widowed _____

Name of Spouse _____ Spouse's Employer _____

Spouse's Occupation _____ Bus. Phone _____

Name/Age of Children _____

BRIEFLY DESCRIBE THE ORTHODONTIC PROBLEM _____

Describe any previous orthodontic treatment/consultation: _____

Indicate your concern for orthodontic treatment:

Very concerned _____, Concerned _____, Indifferent _____, Opposed _____

Which family member(s) has similar dental or facial problems? _____

Which family member(s) received orthodontic treatment? _____

INSURANCE PLAN WHICH MAY COVER ORTHODONTIC TREATMENT _____

MEMBERSHIP NUMBER _____ GROUP NUMBER _____

SUBSCRIBER'S NAME _____

SUBSCRIBER'S IDENTIFICATION NUMBER AND BIRTHDATE _____ -- _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

FAMILY PHYSICIAN _____ Approximate Date of Last Exam _____

GENERAL HEALTH IS: excellent _____, good _____, fair _____, poor _____

Are you under any medical treatment now? _____

LIST ANY MEDICATION YOU ARE PRESENTLY USING: _____

FAMILY DENTIST _____ Approximate Date of Last Exam _____

ORAL HEALTH IS: good _____, fair _____, poor _____ DO YOU FLOSS DAILY? _____

DO YOU HAVE ANY OF THE FOLLOWING HABITS? (check all that apply)

- | | |
|--------------------------|------------------------|
| _____ Finger/Thumb Habit | _____ Lip/Cheek Biting |
| _____ Grinding Teeth | _____ Clenching Teeth |
| _____ Mouth Breathing | _____ Tongue Thrusting |

INTERESTS and HOBBIES _____

(PLEASE CONTINUE TO SECOND PAGE)

DR. LILI K. HORTON
ORTHODONTIST

PATIENT- PAST AND PRESENT MEDICAL HISTORY:

- YES NO
() () Frequent nasal obstruction _____, Earaches _____, Sore Throat _____
() () Frequent headaches
() () Temporomandibular joint (TMJ or jaw) pain, noise or dysfunction
IF YES, PLEASE ASK FOR OUR TMJ FORM.
() () Have you had any accidents/trauma to face or teeth? ACCIDENT DATE _____
If yes, please describe: _____
() () Have you had any serious problems with any previous dental treatment?
If yes, please explain: _____

() () Allergy to: PENICILLIN _____, ASPIRIN _____, Other Drugs _____,
METALS (Nickel, Chromium/etc.) _____, LATEX (Rubber products) _____
() () Other allergies: Asthma _____, Hayfever _____, Hives _____, Skin Rash _____, Other _____
() () Sore on lips, in mouth, or on skin (persistent or recurring)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

IF NO, PLEASE CHECK HERE _____.

IF YES, PLEASE CHECK ALL THAT APPLY.

- | | |
|--------------------------------------|--|
| _____ Anemia | _____ Rheumatic Fever |
| _____ Bleeding Problems | _____ Rheumatic Heart Disease |
| _____ Diabetes | _____ Eye Problems |
| _____ Thyroid Problems | _____ Ear/Hearing Problems |
| _____ Respiratory Disease | _____ Stomach/Intestinal Disease |
| _____ Cold sores/Canker sores/Herpes | _____ Cancer |
| _____ Fainting/Epilepsy/Seizures | _____ Liver Disease/Jaundice |
| _____ Emotional Disorders | _____ Hepatitis |
| _____ Kidney Disease | _____ Tuberculosis (TB) |
| _____ Arthritis | _____ HIV/AIDS |
| _____ Bone Disease | _____ Venereal Disease (VD) |
| _____ Arteriosclerosis | _____ Other Infectious Disease |
| _____ High/Low Blood Pressure | <i>If yes, is it controlled?</i> _____ |
| _____ Heart Problems | <i>If yes, please explain:</i> _____ |

DO YOU HAVE ANY DISEASE OR CONDITION NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT?

IF NO, PLEASE CHECK HERE _____.

IF YES, PLEASE EXPLAIN: _____

FEMALES: Are you pregnant? NO _____ YES _____

PATIENT'S SIGNATURE _____ DATE _____